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Issue Brief: Women and Gender Issues in Public Health

Key Words

Women, Gender, Public Health, Reproductive Health, Abortion, Breast Cancer, HIV/AIDs, Transgender, Healthcare, Affordable Care Act

Description

This issue brief outlines public health concerns for minority women and transgender persons. It focuses primarily on reproductive health, breast cancer, HIV/AIDs, specific health issues faced by transgender persons, and healthcare coverage.

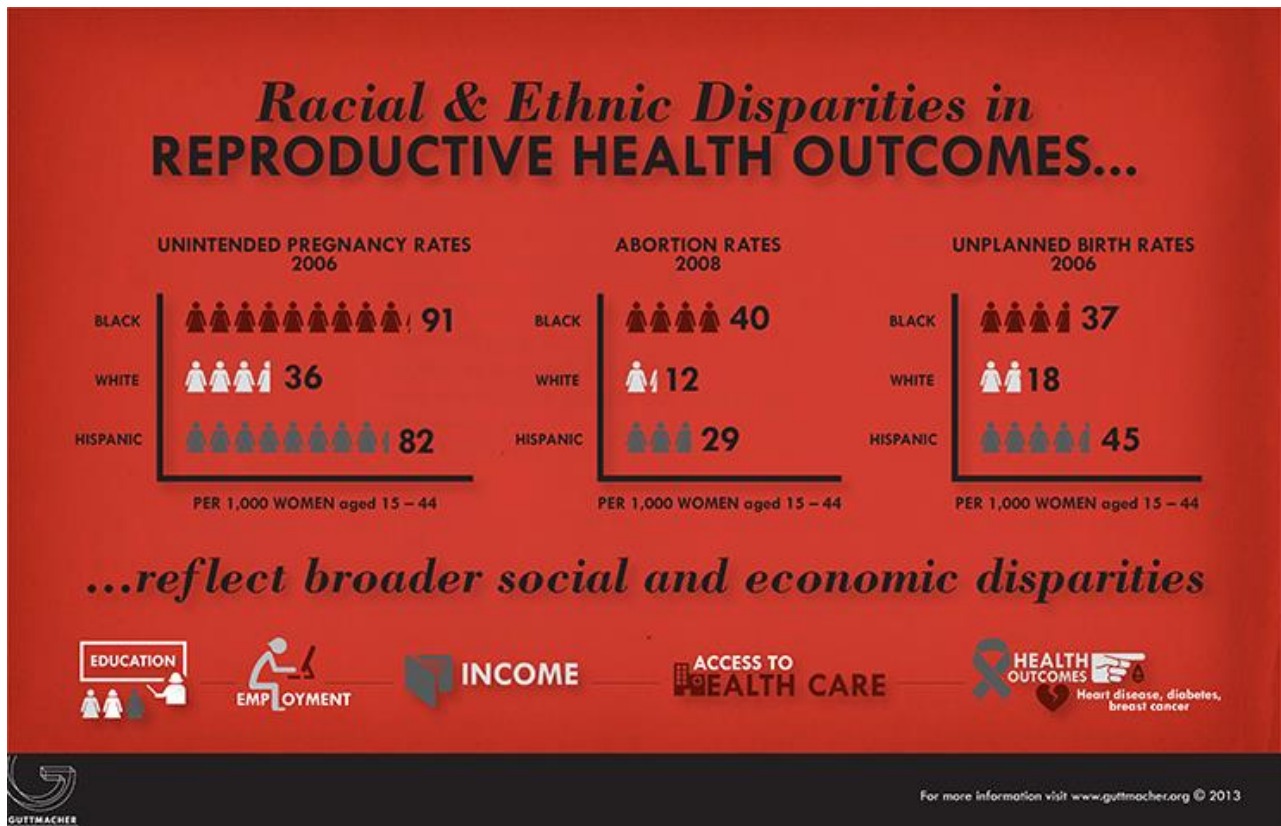
Key Points

- Many of the issues discussed in this brief are the result of barriers to health care, a feature that is strongly associated with socioeconomic status and as a result, contains a large racial and ethnic component. Hispanics, African Americans, and Native Americans and Alaskan Natives are particularly impacted by such barriers.
- Attempts to curb access to abortion disproportionately impact minority women, as they have higher rates of unplanned pregnancies and lack access to quality medical coverage and care.
- Breast cancer deaths and HIV/AIDs infection rates are higher among female African American than women of all other racial and ethnic groups within the United States
- Transgender persons face unique health challenges, such as medical coverage discrimination and alarmingly high rates of attempted suicide.
- The Affordable Care Act seeks to reduce health disparities through the expansion of current programs and new regulation. However, some areas surrounding abortion and trans-related care are still uncovered by the ACA.

Reproductive Health

Abortion remains one of the most enduring and contentious policy issues in the United States, where battles are routinely waged in town halls, state houses, and on Capitol Hill. Despite the surrounding controversy, approximately one in three women will have an abortion before they reach 45. According to the Centers for Disease Control, there were 825,564 abortions reported in the United States for 2008, with an average of 16 abortions per 1000 women between the ages of 15 and 64. Respectively, Whites, Blacks and Hispanics, account for 36%, 30%, and 25% of abortions, while all other racial and ethnic categories account for 9% of abortions. However, abortions and unplanned pregnancies are disproportionately concentrated among women living below the federal poverty line as well as among Hispanic and African-American women—91 and 82 per 1000, respectively. Women living in poverty represent 42% of all abortions. Additionally, 33% of patients do not have medical insurance, 31% are covered by Medicaid, and 57% of all patients—regardless of coverage status—pay cash for their procedure.

State governments have enacted laws and amendments designed to curb and or prevent abortions. For example, some states require that patients receive ultrasounds, counseling, and face prolonged waiting periods prior to a procedure. Also targeted are the use of drugs for non-surgical abortions, where some states have either banned the procedure or issued prohibitive standards for their application, such as requiring the drug's consumption in front of a licensed physician. The aforementioned procedures present an economic burden for both urban and rural poor: Excessive and constant travel times significantly increase costs.



Lastly, coverage of abortion under Medicaid and the Affordable Care Act is limited under provisions detailed in the Hyde Amendment.¹ The amendment restricts federal funding of abortions to instances of rape, incest, and life endangerment. As of this briefing's completion, only 17 states and the District of Columbia authorize state funds for abortions beyond the parameters for Medicaid and ACA coverage. Under the ACA, however, private plans may cover abortions beyond federal restrictions, should the state not outlaw abortions.

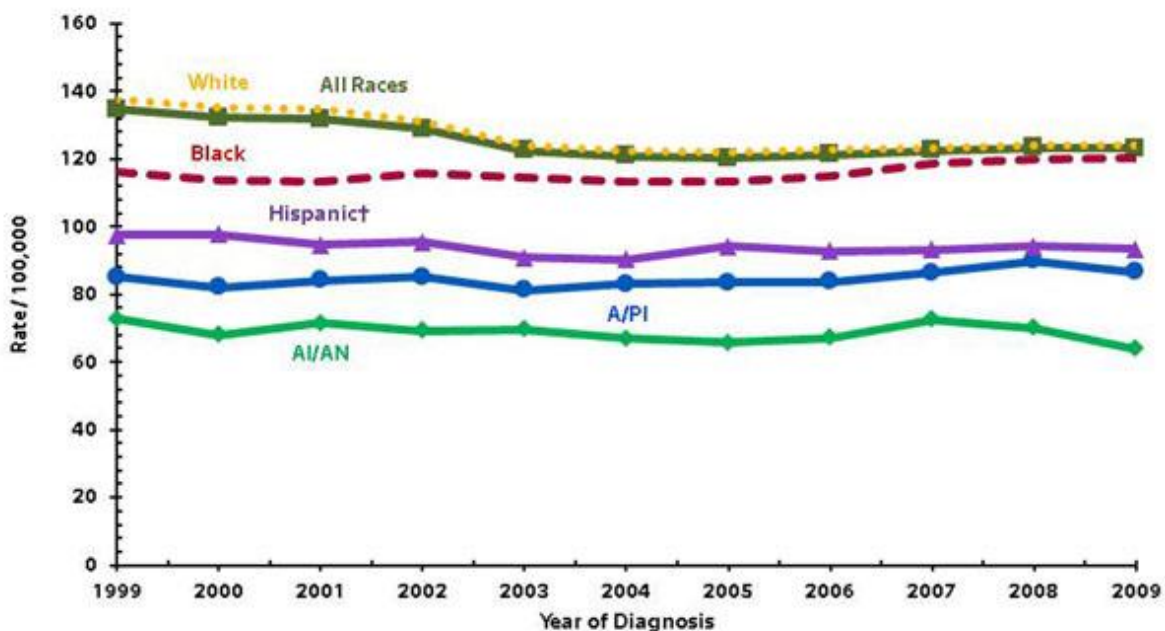
Disparities and Remedies in Healthcare

Ethnic and Racial minorities face large disparities in healthcare relative to their white female counterparts. Incidents of HIV/AIDS infection, Breast Cancer deaths, domestic and sexual violence, as well as insurance coverage all disproportionately affect Black, Hispanic, and Native American and Alaskan Native women. For example, Black women are less likely to be

¹ The Hyde Amendment is attached annually by Congress to The Department of Health and Human Services' appropriations bill, for details see <http://www.factcheck.org/2010/04/the-abortion-issue/>

diagnosed with breast cancer than white women.² However, at 30.5 deaths per 100,000 people, black women are 40% more likely to die from breast cancer than white women, at 21.6 deaths per 100,000, and have a higher death rate than all other races combined, 22.2 per 100,000. This is due to a particularly aggressive form of breast cancer more common in African American women, many of whom receive follow up care and begin treatment later than white women.³ Once implemented, the ACA will extend treatment coverage and provide important educational information.

Breast cancer diagnoses, by race (CDC):



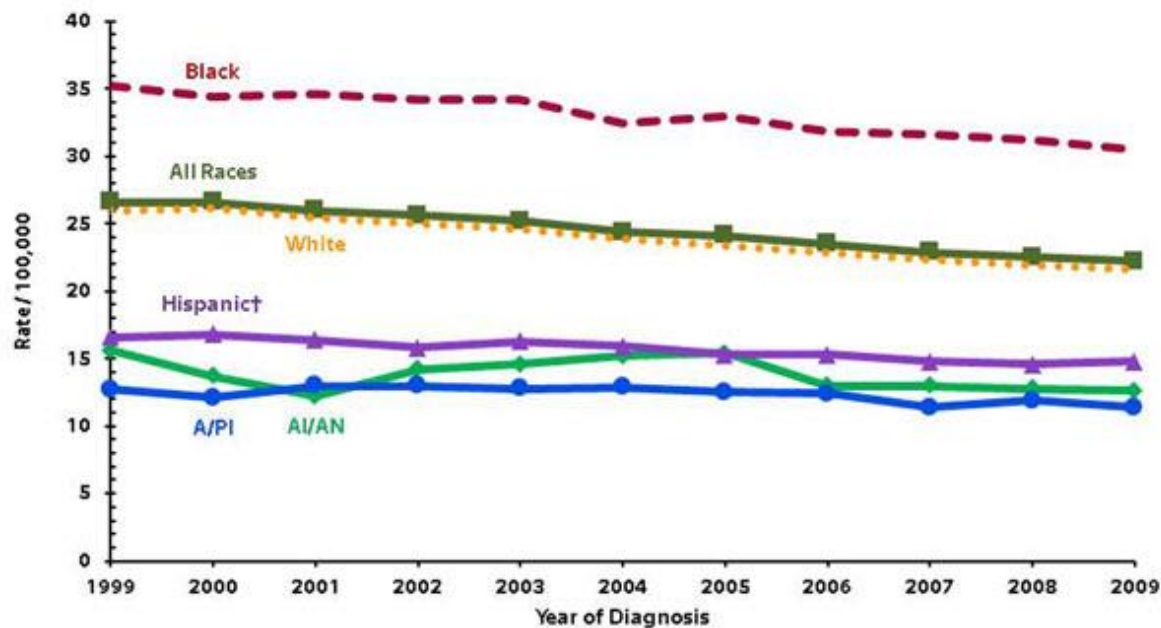
² Black and white women report almost identical rates of breast cancer screening, for details see

<http://www.cdc.gov/cancer/breast/statistics/screening.htm>

³ Triple Negative Breast Cancer accounts for 20% of breast cancers diagnoses for African American women, for details see

http://www.tnbcfoundation.org/tnbcnews_blackwomen.htm

Breast cancer deaths, by race (CDC):



The ACA will also significantly expand HIV/AIDS prevention and treatment coverage. Currently, 30% of infected persons are not covered by a health insurance plan and only 17% are covered by a private insurer, further emphasizing the socio-economic disparity in HIV/AIDS infection and treatment. HIV/AIDS infections are higher among black, Hispanic, and Native American women, standing at 38, 11.8, and 3 per 100,000 people, respectively. By contrast, white women are infected at an annual rate of 2.6 per 100,000 people. However, in 2010, Black women for the first time experienced a declining HIV/AIDS infection rate. A wide range of barriers continue to prevent many suffering from HIV/AIDS from accessing treatment, some examples include: Community and cultural stigma, fear of disclosure, limited English proficiency, a mobile and remote agricultural workforce, and fear of isolation from their respective communities.

While the ACA cannot alleviate every issue mentioned above, it will provide every substantial access to comprehensive and preventative care. Insurers are prohibited from denying coverage or mandating caps on benefits. Funds from the AIDs Drug Assistant Program (ADAP), a government program designed to provide financial support for drug purchases, will count as a patient's out of pocket expense. Lastly, Women are usually charged higher insurance rates than men, a practice referred to as gender-rating, as men are assessed as less likely to require medical treatment. The ACA will prohibit gender-rating beginning in 2014.

Transgender Persons and Public Health

The ACA will extend coverage protections for transgender persons by prohibiting gender-based discrimination by insurers. Some insurers treat transgender persons as having a pre-existing condition, due to their gender dysphoria, and have denied coverage for non-trans related care. A 2011 survey revealed that 21% of Latino and 23% of African American respondents reported they had been denied medical care as a result of their gender identity, compared with 17% of whites. The ACA will prohibit denial of coverage and service due to gender identity, however, it will not cover trans related care such as hormone replacement therapy.

Mental health is also an area of significant concern, where 56% of Native Americans, 49% of African Americans, and 47% of Hispanics reported that they had attempted suicide, compared with 39% of Asian Americans and 38% of whites. Lastly, the government does not take a population count of the transgender population, perhaps preventing more substantive and directed policy action.

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Triple Negative Breast Cancer Foundation

Breast Cancer

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